Editorials

$250,000—Was It Worth It?

THE FINAL PARAGRAPH in a case report appearing elsewhere in this issue raises a troubling question. A 34-year-old man with a history of intravenous drug abuse was treated and cured of nine separate episodes of endocarditis between 1972 and 1984, when his cultures for pathogens remained sterile after he said he had discontinued intravenous drug use. He had been in hospital for more than a full year out of the past 12 and it was estimated that this patient received almost $250,000 worth of health care.

$250,000—Was it worth it? The final outcome is surely a major medical success story. Nine separate episodes of endocarditis caused by a variety of pathogenic organisms were each separately cured. After 12 years in and out of hospital this patient finally desisted from his intravenous drug abuse and has presumably been well since. The goals of health care for this patient were achieved in truly spectacular fashion.

But a nagging problem persists. Is this the best value that could be got for $250,000 in health care? No one would have said not to treat this patient, even so heroically. But was it worth it, or did others, who perhaps did not abuse themselves at public expense, not get health care they needed because public funds were not available? Questions such as these will not soon go away.

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Demographic Changes and Health Professions Education

CONVENTIONAL WISDOM hath it that there are now enough, and perhaps too many, physicians and other health professionals in practice, or there will soon be, and that it is time to cut back substantially on health professions education. This conventional wisdom assumes that the free market will supply the unmet health care needs for medically underserved "minority" ethnic groups and distribute health care providers more evenly to the medically underserved inner-city and remote rural areas. But if one delves a little deeper, one finds that many "majority" health professionals find themselves poorly trained to practice where the needs are greatest and that they tend to congregate in places and situations where they feel more comfortable with their "majority" background and training. In any case, improvement in the health status of the medically underserved has been disappointingly slow.

These problems are further exacerbated by a changing demography, particularly in the West. In California, at least, the ethnic minorities in the aggregate will become the numerical majority during the practice lifetime of many physicians and other health professionals who are in practice today. At the same time, another minority, the elderly in the population, is beginning to increase dramatically in both age and numbers. Many of these will also be medically underserved, unless something is done in the area of health professions education and training.

Elsewhere in this issue, Davidson and Montoya address one aspect of this problem. They have shown that the recruitment and training of minority health professionals can bring about a better distribution of health care to medically underserved populations. This is an important observation and one senses that when enough minority physicians and other health professionals are recruited and trained, so that the proportion of minority health professionals in a minority ethnic population more nearly matches the proportion of all health professionals to the general population, much of this problem will be solved. These recruitment and training efforts should and will continue, but it will be some time before any sort of numerical match occurs.

But what can be done more quickly to improve health care for medically underserved groups or populations? Can something be done through a cooperative effort? Who has a stake in this? Can health professions education help to address this problem? Clearly the communities with medically underserved populations have a stake. So do the health professions. So do the institutions that educate and train health professionals and prepare them for practice. And so does government. The evidence is accumulating that cooperative efforts among these parties at interest can occur, and when they do, they can make a difference in health professions education and in health care in medically underserved communities. In these areas of growing health care needs and in this era of growing technologic, social, economic and political interdependence, cooperative approaches among the interested parties may well be the way to go. The opportunities to improve the education and training of health professionals for practice in and with medically underserved communities are great. These efforts to improve health care for the medically underserved should be given the collaborative support that is needed. It can make a difference, and probably a great difference, if done with the full support of all concerned.

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Intestinal Manifestations of the Acquired Immunodeficiency Syndrome

DURING the past five years, the world has witnessed the emergence and spread of a new syndrome, AIDS. The causative agent, the human immunodeficiency virus (HIV), is a retrovirus that infects T-helper lymphocytes as well as other cells and produces a progressive deficiency of cellular immune function. While the precise pathogenetic mechanisms remain unclear, knowledge of the epidemiologic and virologic characteristics of AIDS is advancing rapidly and should lead to strategies for effective treatment and prevention.

The consequences of HIV infection upon the mucous membranes have been relatively unexplored despite much evidence of mucous membrane dysfunction in patients with AIDS. Mucous membranes may be viewed as lipid membranes whose epithelial cell intercellular junctions and cell surface membrane transport proteins confer an extremely selective permeability to soluble and particulate antigens. The mucous membranes face nonsterile environments but lack an